		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0020925

Facility Name: North Adams Home

Address: Box 100 (Number) Mendon (City) 62351 (Zip Code)

County: Adams

Telephone Number: 217 936-2137 **Fax #**

IDPA ID Number: 37-0978651001

Date of Initial License for Current Owners: 10-16-77

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
x	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501 © 3		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: James G. Hull **Telephone Number:** 217 228-1950

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 11/01/99 to 10/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title) James G. Hull, V.P.
(Firm Name & Address) Wdm Computer Services, Inc. , 1900 Harrison, Quincy, IL 62
(Telephone) 217-228-1950 Fax # 217-222-6053

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number North Adams Home # 0020925 Report Period Beginning: 11/01/99 Ending: 10/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 08/09/99

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	115	Skilled (SNF)	115	42,090	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	115	TOTALS	115	42,090	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	3,212	1,632		4,844	8
9	SNF/PED					9
10	ICF	17,815	16,148		33,963	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,027	17,780		38,807	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.20%

D. How many bed-hold days during this year were paid by Public Aid?
116 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Meals Plus, P.T., Outpatient

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [x]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [x] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 10/16/77

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [x] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 10/31/99 Fiscal Year: 10/31/99

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number North Adams Home # 0020925 **Report Period Beginning:** 11/01/99 **Ending:** 10/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	205,940	18,245	5,170	229,355		229,355		229,355			1
2	Food Purchase		178,577		178,577		178,577	(18,016)	160,561			2
3	Housekeeping	84,992	19,487		104,479		104,479		104,479			3
4	Laundry	86,176	24,640		110,816		110,816		110,816			4
5	Heat and Other Utilities			109,521	109,521		109,521		109,521			5
6	Maintenance	53,193	14,758	76,803	144,754	206	144,960		144,960			6
7	Other (specify):*											7
8	**TOTAL General Services**	430,301	255,707	191,494	877,502	206	877,708	(18,016)	859,692			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,405,130	63,312	3,495	1,471,937		1,471,937	(9,604)	1,462,333			10
10a	Therapy	66,009	2,657	6,202	74,868		74,868	(187)	74,681			10a
11	Activities	77,642	5,895		83,537		83,537	(387)	83,150			11
12	Social Services	43,751	304	3,727	47,782		47,782		47,782			12
13	Nurse Aide Training		204	1,493	1,697		1,697		1,697			13
14	Program Transportation		4,670		4,670		4,670	(7,223)	(2,553)			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,592,532	77,042	26,917	1,696,491		1,696,491	(17,401)	1,679,090			16
	C. General Administration											
17	Administrative	83,976			83,976		83,976		83,976			17
18	Directors Fees											18
19	Professional Services			43,208	43,208		43,208		43,208			19
20	Dues, Fees, Subscriptions & Promotions			40,623	40,623		40,623	(13,998)	26,625			20
21	Clerical & General Office Expenses	62,060	30,879		92,939		92,939	(278)	92,661			21
22	Employee Benefits & Payroll Taxes			256,568	256,568		256,568		256,568			22
23	Inservice Training & Education			2,200	2,200	(206)	1,994		1,994			23
24	Travel and Seminar			7,762	7,762		7,762		7,762			24
25	Other Admin. Staff Transportation		3,169		3,169		3,169		3,169			25
26	Insurance-Prop.Liab.Malpractice			13,153	13,153		13,153		13,153			26
27	Other (specify):*			195	195		195	(195)				27
28	**TOTAL General Administration**	146,036	34,048	363,709	543,793	(206)	543,587	(14,471)	529,116			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,168,869	366,797	582,120	3,117,786		3,117,786	(49,888)	3,067,898			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number North Adams Home #0020925 Report Period Beginning: 11/01/99 Ending: 10/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			172,045	172,045		172,045	(551)	171,494			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			129,360	129,360		129,360	(1,407)	127,953			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			3,524	3,524		3,524		3,524			35
36	Other (specify):*			3,824	3,824		3,824	(2,003)	1,821			36
37	**TOTAL Ownership**			308,753	308,753		308,753	(3,961)	304,792			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation		990		990		990		990			38
39	Ancillary Service Centers		123,491	2,748	126,239		126,239	(4,500)	121,739			39
40	Barber and Beauty Shops		823	16,713	17,536		17,536		17,536			40
41	Coffee and Gift Shops		8,384		8,384		8,384		8,384			41
42	Provider Participation Fee			63,135	63,135		63,135		63,135			42
43	Other (specify):*		15	478	493		493	(478)	15			43
44	**TOTAL Special Cost Centers**		133,703	83,074	216,777		216,777	(4,978)	211,799			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,168,869	500,500	973,947	3,643,316		3,643,316	(58,827)	3,584,489			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number North Adams Home # 0020925 Report Period Beginning: 11/01/99 Ending: 10/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients	(187)	10a		2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(17,134)	2		4
5	Telephone, TV & Radio in Resident Rooms	(278)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients	(79)	10		7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(416)	30		9
10	Interest and Other Investment Income	(1,407)	32		10
11	Discounts, Allowances, Rebates & Refunds	(882)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(478)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(195)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(13,998)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Attatched	(23,393)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (58,447)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*	(380)	11	32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (380)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (58,827)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

North Adams Home

ID# 0020925

Report Period Beginning: 11/01/99

Ending: 10/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Non-care Depreciation	$ (135)	30	1
2	Private P.T./Oxygen	(8,230)	10	2
3	Pharmacy 3rd Party Revenue	(4,500)	39	3
4	Activities Program Income	(7)	11	4
5	Misc Expenses	(1,287)	36	5
6	Bank/Service Fees	(716)	36	6
7	Nursing Supplies Private	(1,295)	10	7
8	Bus Trips Private	(7,223)	14	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
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78				78
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81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	(23,393)		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number North Adams Home # 0020925 Report Period Beginning: 11/01/99 Ending: 10/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(18,016)	0	0	0	0	0	0	0	0	0	0	(18,016)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(18,016)	0	0	0	0	0	0	0	0	0	0	(18,016)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(9,604)	0	0	0	0	0	0	0	0	0	0	(9,604)	10
10a	Therapy	(187)	0	0	0	0	0	0	0	0	0	0	(187)	10a
11	Activities	(387)	0	0	0	0	0	0	0	0	0	0	(387)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(7,223)	0	0	0	0	0	0	0	0	0	0	(7,223)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(17,401)	0	0	0	0	0	0	0	0	0	0	(17,401)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(13,998)	0	0	0	0	0	0	0	0	0	0	(13,998)	20
21	Clerical & General Office Expenses	(278)	0	0	0	0	0	0	0	0	0	0	(278)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(195)	0	0	0	0	0	0	0	0	0	0	(195)	27
28	**TOTAL General Administration**	(14,471)	0	0	0	0	0	0	0	0	0	0	(14,471)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(49,888)	0	0	0	0	0	0	0	0	0	0	(49,888)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number North Adams Home # 0020925 **Report Period Beginning:** 11/01/99 **Ending:** 10/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(551)	0	0	0	0	0	0	0	0	0	0	(551)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,407)	0	0	0	0	0	0	0	0	0	0	(1,407)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	(2,003)	0	0	0	0	0	0	0	0	0	0	(2,003)	36
37	**TOTAL Ownership**	(3,961)	0	0	0	0	0	0	0	0	0	0	(3,961)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	(4,500)	0	0	0	0	0	0	0	0	0	0	(4,500)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(478)	0	0	0	0	0	0	0	0	0	0	(478)	43
44	**TOTAL Special Cost Centers**	(4,978)	0	0	0	0	0	0	0	0	0	0	(4,978)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(58,827)	0	0	0	0	0	0	0	0	0	0	(58,827)	45

Facility Name & ID Number North Adams Home # 0020925 Report Period Beginning: 11/01/99 Ending: 10/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				North Adams Home	Mendon	Medical Clinic
				North Adams Home	Mendon	Cottages

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [x] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number North Adams Home # 0020925 Report Period Beginning: 11/01/99 Ending: 10/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number North Adams Home # 0020925 Report Period Beginning: 11/01/99 Ending: 10/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number North Adams Home # 0020925 Report Period Beginning: 11/01/99 Ending: 10/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Bank One		x	Mortgage	$17,461.00	8/23/97	$ 2,000,000	$ 1,582,285	3/23/01	6.4400	$ 109,349	1
2	Caterpillar		x	Generator	$454.00	11/21/97	14,412	451	11/21/00	8.3120	273	2
3												3
4												4
5												5
	Working Capital											
6	Bank One		x	Cash Flow	Interest	8/23/97		245,837	n/a	10.5000	19,738	6
7												7
8												8
9	TOTAL Facility Related				$17,915.00		$ 2,014,412	$ 1,828,573			$ 129,360	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 2,014,412	$ 1,828,573			$ 129,360	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number North Adams Home **#** 0020925 **Report Period Beginning:** 11/01/99 **Ending:** 10/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1995		8
1996		9
1997		10
1998		11
1999		12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number North Adams Home # 0020925 Report Period Beginning: 11/01/99 Ending: 10/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 48,950 B. General Construction Type: Exterior Brick Frame Fire Resistant Number of Stories 1

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

North Adams Home, Inc., Medical Clinic, 2567 Sq Ft
North Adams Home, Inc., Cottages, 2756 Sq Ft

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Patient Care	435,600	1975	$ 22,893	1
2					2
3	TOTALS	435,600		$ 22,893	3

Facility Name & ID Number North Adams Home # 0020925 Report Period Beginning: 11/01/99 Ending: 10/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	88		1977	1977	$ 1,036,037	$ 25,944	40	$ 25,901	$ (43)	$ 594,976	4
5	1		1978	1978	2,633		10			2,633	5
6	10		1986	1986	438,224	14,673	30	14,607	(66)	208,348	6
7	10		1997	1997	1,374,932	34,442	40	34,373	(69)	122,290	7
8											8
	Improvement Type**										
9	Garage			1981	26,358	1,352	20	1,318	(34)	25,907	9
10	Building Improvement			1979	1,158					1,158	10
11	Building Improvement			1980	187					187	11
12	Building Improvement			1981	121					121	12
13	Building Improvement			1983	2,105					2,105	13
14	Building Improvement			1985	1,082					1,082	14
15	Land Improvement			1977	6,339					6,339	15
16	Land Improvement			1978	3,756					3,756	16
17	Land Improvement			1979	15,608					15,608	17
18	Land Improvement			1980	1,556	5	20	5		1,556	18
19	Land Improvement			1982	337					337	19
20	Land Improvement			1983	11,703					11,703	20
21	Land Improvement			1985	2,618					2,618	21
22	Land Improvement (IDPA)			1986	7,661					7,661	22
23	Generator			1979	11,412					11,412	23
24	Intercom System			1980	1,319					1,319	24
25	Fixed Equipment			1982	29,082					29,082	25
26	Building Improvement			1986	28,142	1,915	15	1,876	(39)	26,067	26
27	Building Improvement			1986	47,328	3,221	15	3,155	(66)	43,839	27
28	Building Improvement			1987	9,880	671	15	659	(12)	8,873	28
29	Building Improvement			1987	4,145	282	15	276	(6)	3,700	29
30	Building Improvement			1987	6,319	429	15	421	(8)	5,640	30
31	Building Improvement			1987	3,244	220	15	216	(4)	2,858	31
32	Land Improvement (IDPA)			1986	10,159					10,159	32
33	Land Improvement (IDPA)			1987	1,192					1,192	33
34	Land Improvement			1987	1,255					1,255	34
35	Wall Carpet			1988	12,374	838	15	825	(13)	10,419	35
36	TOTAL (lines 4 thru 35)				$ 3,098,266	$ 83,992		$ 83,632	$ (360)	$ 1,164,200	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number North Adams Home # 0020925 Report Period Beginning: 11/01/99 Ending: 10/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Cabinets/doors			1988	5,316	266	20	266		3,256	9
10	Sprinklers			1988	663	27	25	27		325	10
11	Exhaust Fan/Door Locks			1988	2,151	143	15	143		1,733	11
12	Sidewalk & Sheltor Floor			1988	2,583		10			2,583	12
13	Land Improvements			1988	3,052		10			3,052	13
14	Patient Sensor System			1989	3,964		10			3,964	14
15	Dining Room Remodel			1989	3,943	263	15	263		2,957	15
16	Garage			1990	31,318	1,044	30	1,044		10,527	16
17	Parking Lot Paving			1990	10,500	963	10	963		10,500	17
18	Roof			1991	82,210	4,128	20	4,111	(17)	38,869	18
19	Patio			1994	15,076	1,508	10	1,508		9,299	19
20	Electric Doors			1994	2,867	191	15	191		1,131	20
21	Storage Room			1995	1,662	111	15	111		609	21
22	Patient Sensor System			1996	2,340	236	10	234	(2)	1,080	22
23	Landscaping			1996	776	78	10	78		325	23
24	Carpet			1996	1,183	79	15	79		337	24
25	Ventilation			1996	1,154	77	15	77		309	25
26	Nursing Cabinets			1996	9,378	629	15	625	(4)	2,512	26
27	New Addition - Garden			1997	25,624	2,586	10	2,562	(24)	9,249	27
28	New Addition - Egress			1997	4,431	447	10	443	(4)	1,599	28
29	Laundry Remodel			1997	13,967	936	15	931	(5)	2,886	29
30	Re-roof			1998	5,232	349	15	349		857	30
31	Alarm System			1999	2,466	164	15	164		247	31
32	Roof repairs			1999	11,000	733	15	733		1,100	32
33	Lanscaping			1999	992	99	10	99		116	33
34	Shower Remodel			1999	2,792	106	20	106		106	34
35	Power Door (scu)			2000	1,233	72	10	72		72	35
36	TOTAL (lines 4 thru 35)				$ 247,873	$ 15,235		$ 15,179	$ (56)	$ 109,600	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number North Adams Home # 0020925 Report Period Beginning: 11/01/99 Ending: 10/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	New Railing			2000	670	33	10	33		33	9
10	Fire Wall			2000	21,922	274	20	274		274	10
11	Oxygen Room			2000	2,409	30	20	30		30	11
12	Dampers			2000	2,581	43	15	43		43	12
13	Duct Detectors			2000	2,285	57	10	57		57	13
14	Emergency Lighting			2000	2,119	53	10	53		53	14
15	Smoke/Fire Dampers			2000	1,300	22	10	22		22	15
16	Emergency Lighting			2000	801	13	10	13		13	16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 34,087	$ 525		$ 525	$	$ 525	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number North Adams Home # 0020925 Report Period Beginning: 11/01/99 Ending: 10/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 617,418	$ 61,683	$ 61,683	$	15-5	$ 284,084	37
38	Current Year Purchases	42,261	2,895	2,895		15-5	2,895	38
39	Fully Depreciated Assets	188,340				15-5	188,340	39
40								40
41	TOTALS	$ 848,019	$ 64,578	$ 64,578	$		$ 475,319	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Patient Transportaion	1980 Ford Van	1990	$ 45,725	$	$	$	5	$ 45,725	42
43	Patient Transportaion	Bus	1999	37,900	7,580	7,580		5	8,212	43
44										44
45										45
46	TOTALS			$ 83,625	$ 7,580	$ 7,580	$		$ 53,937	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 4,334,763	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 171,910	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 171,494	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ (416)	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 1,803,581	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	Cottage #1	$ 75,325	$ 2,404	$ 45,872	52
53	Medical Clinic	176,944	5,684	109,214	53
54	Land Trust	49,865			54
55	Beauty & Barber	1,234		1,234	55
56	See Attatched List	426,954	13,734	99,246	56
57	TOTALS	$ 730,322	$ 21,822	$ 255,566	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number North Adams Home # 0020925 Report Period Beginning: 11/01/99 Ending: 10/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 3,524 Description: O2 Concentrators, nebulizer
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number North Adams Home # 0020925 Report Period Beginning: 11/01/99 Ending: 10/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [x] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [x]
- HOURS PER AIDE 100

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [x]
- HOURS PER AIDE 55

B. EXPENSES

ALLOCATION OF COSTS (d)

			1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition		$	$ 1,493	$	$ 1,493
2	Books and Supplies			204		204
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$	$ 1,697	$	$ 1,697
10	SUM OF line 9, col. 1 and 2	(e)	$ 1,697			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care	10-3	visits		10	135		10	135	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-3	# of prescrpts		96	2,748		96	2,748	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$	106	$ 2,883	$	106	$ 2,883	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number North Adams Home **#** 0020925 **Report Period Beginning:** 11/01/99 **Ending:** 10/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 10/31/00 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 18,002	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	265,697		3
4	Supply Inventory (priced at fifo)	37,196		4
5	Short-Term Investments			5
6	Prepaid Insurance	9,034		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 329,929	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	242,756		12
13	Land	72,758		13
14	Buildings, at Historical Cost	4,041,199		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	922,053		16
17	Accumulated Depreciation (book methods)	(2,030,066)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): bond refinancing (net)	23,350		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,272,050	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,601,979	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 78,675	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	245,837		29
30	Accrued Salaries Payable	180,453		30
31	Accrued Taxes Payable (excluding real estate taxes)	1,688		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37	employee fund	108		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 506,761	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	451		39
40	Mortgage Payable	1,662,912		40
41	Bonds Payable			41
42	Deferred Compensation	109,510		42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,772,873	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,279,634	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,322,345	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,601,979	$	48

***(See instructions.)**

Facility Name & ID Number North Adams Home # 0020925 Report Period Beginning: 11/01/99 Ending: 10/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,467,584	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,467,584	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(140,806)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Cottages (net loss)**	(3,110)	15
16	Other (describe) **Medical Clinic (net loss)**	(1,323)	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (145,239)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,322,345	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number North Adams Home # 0020925 Report Period Beginning: 11/01/99 Ending: 10/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,275,501	1
2	Discounts and Allowances for all Levels	(1,317)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,274,184	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	7,511	6
7	Oxygen	906	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 8,417	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	7,369	12
13	Barber and Beauty Care	19,086	13
14	Non-Patient Meals	17,134	14
15	Telephone, Television and Radio	278	15
16	Rental of Facility Space		16
17	Sale of Drugs	117,890	17
18	Sale of Supplies to Non-Patients	79	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	561	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 162,397	23
	D. Non-Operating Revenue		
24	Contributions	43,614	24
25	Interest and Other Investment Income***	1,407	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 45,021	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Transportation Income	8,213	28
28a	See Attatched List	4,278	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 12,491	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,502,510	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	877,502	31
32	Health Care	1,696,491	32
33	General Administration	543,793	33
	B. Capital Expense		
34	Ownership	308,753	34
	C. Ancillary Expense		
35	Special Cost Centers	153,642	35
36	Provider Participation Fee	63,135	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,643,316	40
41	**Income before Income Taxes (line 30 minus line 40)****	(140,806)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (140,806)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number North Adams Home # 0020925 Report Period Beginning: 11/01/99 Ending: 10/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,034	2,159	$ 44,046	$ 20.40	1
2	Assistant Director of Nursing	1,840	1,917	33,545	17.50	2
3	Registered Nurses	21,593	23,521	363,517	15.45	3
4	Licensed Practical Nurses	29,174	30,725	351,806	11.45	4
5	Nurse Aides & Orderlies	65,174	68,203	583,599	8.56	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,697	7,068	66,009	9.34	8
9	Activity Director	2,004	2,088	21,882	10.48	9
10	Activity Assistants	7,330	7,945	55,760	7.02	10
11	Social Service Workers	4,202	4,300	43,751	10.17	11
12	Dietician					12
13	Food Service Supervisor	1,996	2,237	21,797	9.74	13
14	Head Cook					14
15	Cook Helpers/Assistants	14,673	15,626	103,251	6.61	15
16	Dishwashers	11,758	12,248	80,892	6.60	16
17	Maintenance Workers	5,162	5,473	53,193	9.72	17
18	Housekeepers	10,726	11,451	84,992	7.42	18
19	Laundry	10,074	10,659	86,176	8.08	19
20	Administrator	2,064	2,279	52,312	22.95	20
21	Assistant Administrator	2,082	2,113	31,664	14.99	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,834	6,213	55,996	9.01	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,086	3,192	28,617	8.97	31
32	Other Health Care(specify)	693	693	6,064	8.75	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	208,196	220,110	$ 2,168,869 *	$ 9.85	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	188	$ 5,170	1-3	35
36	Medical Director	104	12,000	9-3	36
37	Medical Records Consultant	28	1,393	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	102	4,297	10A-3	40
41	Occupational Therapy Consultant	10	461	10A-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	19	1,444	10A-3	43
44	Activity Consultant				44
45	Social Service Consultant	58	3,370	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	509	$ 28,135		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides	37	565	10-3	52
53	TOTAL (lines 50 - 52)	37	$ 565		53

Facility Name & ID Number North Adams Home # 0020925 Report Period Beginning: 11/01/99 Ending: 10/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
John Bainum	Administrator	0	$ 52,312
Greg Sandidge	Asst. Administrator	0	31,664
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 83,976

B. Administrative - Other

Description	Amount
N/A	$ 0
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
WDM Computer Services	Accounting	$ 32,420
Hubert Staff	Legal	4,325
ABDG Accounting	Audit/Tax Return	6,463
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 43,208

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 37,523
Unemployment Compensation Insurance	17,684
FICA Taxes	160,874
Employee Health Insurance	40,487
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
TOTAL (agree to Schedule V, line 22, col.8)	$ 256,568

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$ 0
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	14,584
Health Care Worker Background Check	552
(Indicate # of checks performed 46)	
LSN Memberships	4,523
Mes of IL	1,250
LTCS	1,200
INHAA	75
Subscriptions & EBC	3,955
Fees (Lic. & State)	486
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 26,625

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
See Attatched List	7,762
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,762

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number North Adams Home # 0020925 Report Period Beginning: 11/01/99 Ending: 10/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number North Adams Home **#** 0020925 **Report Period Beginning:** 11/01/99 **Ending:** 10/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **See Attatched List**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **9.53**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **7,061** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **63,135**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **Yes** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **4,830**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **Yes** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **990**
c. What percent of all travel expense relates to transportation of nurses and patients? **66**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Arnolds, Behrens, Deters & Gray** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **Yes** If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

SEMINAR TRAVEL
NOVEMBER '99-OCTOBER '00

Given back by Sandee Marcineck from Seminar of Oct.'99	($15.73)
Registration for Oct. Seminar paid on Mastercard bill in Dec.00	$495.00

NAME: Basic Rehabilitation & Restorative Care
DATE: November 5,6, 1999
ATTENDED BY: Kathy Spohr, Brenda Blickhan
PLACE: Lincoln Land Community College
Springfield, Il.

Motel	$71.50	
Meals	$48.70	
Gas	$14.50	
	$134.70	$613.97

NAME: Obtaining HCFA Compliance through Increased Awareness
DATE: November 11, 1999
ATTENDED BY: John Bainum, Greg Sandidge, Lisa Bohan, Sandee Marcineck
PLACE: Springfield, Il.
GIVEN BY: The National Institute for Health & Human Service

Registration	$468.00	
Meals	$51.64	
Gas	$54.23	
	$573.87	$1,187.84

NAME: Shattering the Myths
DATE: November 18, 1999
GIVEN BY: : West Central Agrea Agency on Aging
PLACE: Quincy, Illinois
ATTENDED BY: Greg Sandidge

Registration	$35.00	$1,222.84

NAME: Survey & Beyond
DATE: December 1-3, 1999
ATTENDED BY: Kathy Spohr, Lisa Bohan
GIVEN BY: LSN
PLACE: Eagles Ridge Resort, Galena, Il.

Meals & Tips	$37.96	
Gas	$32.04	
	$70.00	$1,292.84

NAME: How to Supervise People
DATE: December 2, 1999
ATTENDED BY: Gay Andrew
PLACE: Days Inn, Quincy, Il
GIVEN BY: Fred Pryor Seminars

Registration	$149.00	$1,441.84

NAME: Culture Change in Long Term Care
DATE: February 1, 2000
ATTENDED BY: Greg Sandidge, Sandee Marcineck
GIVEN BY: Il. Dept. On Aging
PLACE: Bloomington, Il

Registration	$50.00	
Motel	$138.00	
Meals & Tips	$72.75	
Gas	$37.15	
	$297.90	$1,739.74

NAME: Selecting a Nursing Home
GIVEN BY: John Wood Community College
PLACE: Quincy, Il
DATE: Feb 22, 2000
ATTENDED BY: Greg Sandidge,

Registration	$40.00	$1,779.74

NAME: Womens Health Symposium
PLACE: John Wood Community College
ATTENDED BY: Lisa Bohan, Brenda Blickhan, Kathy Archambo
Joyce Hollenberg, Kay Moss
DATE: March 21, 2000

Registration	$300.00	$2,079.74

NAME: Nursing Practice Act
GIVEN BY: John Wood Community College
ATTENDED BY: Lisa Bohan, Kay Moss, Brenda Blickhan
DATE: March 22, 2000

Registration	$200.00	$2,279.74

NAME: MDS Changes & Message Systems Seminar
GIVEN BY: Long Term Care Solutions
PLACE: St. Louis, Missouri
ATTENDED BY: Greg Sandidge, Holly Perrine
DATE: March 24, 2000

Registration	$250.00	
Meals	$13.18	
Gas	$53.15	
	$316.33	$2,596.07

NAME: Alzhemiers Seminar "Creating Meaningful Moments
GIVEN BY: Central Illinois Alzhemiers Association
PLACE: Peoria, Il.
DATE: March 30, 2000
ATTENDED BY: Gay Andrew, Betty Gettman, Helen Ruffcorn,
Kelly Rose

Registration	$200.00	
Meals	$31.18	
Gas	$24.00	
	$255.18	$2,851.25

NAME: Annual Convention & Trade Show
GIVEN BY: Il. Nursing Home Administrators Association
DATE: April 11, 12, 2000
PLACE: Springfield, Il.
ATTENDED BY: John Bainum

Registration	$75.00	
Motel	$200.20	
Meals	$24.32	
Gas	$18.40	
	$317.92	$3,169.17

NAME: Alzhemiers
GIVEN BY: Blessing Affiliates
DATE: April 12, 2000
PLACE: Quincy, Il
ATTENDED BY: Rose Peters, Lisa Ellis

Registration	$40.00	$3,209.17

NAME: Resource Bar Code Training
GIVEN BY:
DATE: April 18, 19, 2000
PLACE: Columbus, Ohio
ATTENDED BY: Greg Sandidge, Raylene Walter

Airfare	$281.75	
Car Rental	$275.67	
Parking, Gas	$50.10	
Motel	$412.08	
Meals & Tips	$146.00	
	$1,165.60	$4,374.77

NAME: Spring Workshop
GIVEN BY: Spoon River Activity Association
DATE: April 10, 2000
PLACE: Macomb, Il.
ATTENDED BY: Gay Andrew

Registration	$25.00	
Meals	$5.58	
	$30.58	$4,405.35

NAME: Diabetes Mellitus Update & Overview
GIVEN BY: Illinois Nurses Association
DATE: May 4, 2000
PLACE: Springfield, Il.
ATTENDED BY: Joyce Hollenberg

Registration	$65.00	$4,470.35

NAME: Train The Trainer
GIVEN BY: Alzhemiers Association
DATE: May 4, 2000
PLACE: Quincy, Il.
ATTENDED BY: Rose Kelly

Registration	$150.00	$4,620.35

NAME: Spring Training Seminar
GIVEN BY: NHRMA
DATE: May 5, 2000
PLACE: Peoria, Il
ATTENDED BY: Dianne Kircher, Beulah Mueggi

Gas	$30.50	
Snacks	$1.65	
	$32.15	$4,652.50

NAME: Inovations in the Future of Long Term Care Software
GIVEN BY: LTCS
DATE: May 8, 2000
PLACE: St. Louis, Missouri
ATTENDED BY: Greg Sandidge

Gas	$84.00	
Meals	$12.68	
	$96.68	$4,749.18

NAME: Medicare Part B
GIVEN BY:
DATE: May 17,2000
PLACE: Macomb, Il
ATTENDED BY: Greg Sandidge

Gas	$33.00	
Meals	$6.83	
	$39.83	$4,789.01

NAME: National Restaurant Show
GIVEN BY
DATE: May 19, 2000
PLACE: Chicago, Il
ATTENDED BY: Greg Sandidge

Registration	$40.00	
Motel	$148.22	
Transportation	$153.00	
Meals	$46.96	
	$388.18	$5,177.19

NAME: INHAA Conference
GIVEN BY: Illinois Nursing Home Administrators Assoc.
DATE: June 7, 8, 2000
PLACE: Bloomington, Il
ATTENDED BY: John Bainum

Registration	$65.00	
Motel	$169.06	
Mileage	$84.00	
Meals	$21.76	
	$339.82	$5,517.01

NAME: Illinois Health Care Association
GIVEN BY: IHCA
DATE: June 14, 2000
PLACE: Springfield, Il
ATTENDED BY: John Bainum

Registration	$150.00	
Motel	$82.15	
Mileage & Parking	$67.00	
Meals	$9.97	
	$309.12	$5,826.13

NAME: Effective MDS Completion & Care Planning
GIVEN BY: Heritage Professional Education
DATE: ########
PLACE: St. Louis
ATTENDED BY: Holly Perrine, Regina Ellerman

Registration	$238.00	
Mileage	$76.44	
Meals	$11.90	
	$326.34	$6,152.47

NAME: Back to the Basics
GIVEN BY: Il. Health Care Association
PLACE: Springfield, Il.
DATE: August 3, 2000
ATTENDED BY: Gay Andrew

Registration	$80.00	$6,232.47

NAME: Pioneering Approaches to Retention in LTC
GIVEN BY:
PLACE: Springfield, Il
DATE: Sept. 13, 2000
ATTENDED BY: Greg Sandidge

Meals	$11.40	$6,243.87

NAME: Stars Among Us
GIVEN BY: Life Service Network
PLACE: Springfield, Il.
DATE: Oct. 3,4, 2000
ATTENDED BY: John Bainum, Greg Sandidge

Registration	$360.00	
Meals & tips	$84.37	
Mileage	$88.48	
Motel	$440.92	
	$973.77	$7,217.64

GIVEN BY: Illinois Activity Association
PLACE: Decatur, Il.
DATE: October 11-13,2000
ATTENDED BY: Gay Andrew, Kas Moellring

Registration	$300.00	
Motel	$80.00	
Meals	$29.37	
	$409.37	$7,627.01

NAME: Sav-A-Day Laundry
GIVEN BY:
PLACE: St. Louis, Mo.
DATE: Oct. 23, 2000
ATTENDED BY: Gene Smith, Ed Hul

Mileage	$79.80	
Meals	$40.00	
	$119.80	$7,746.81

NAME: Spoon River Activity Association
GIVEN BY: Activity Association
PLACE: Macomb, Il
DATE: October 24, 2000
ATTENDED BY: Gay Andrew

Registration	$15.00	$7,761.81

North Adams Home, Inc. 0020925
11/01/99 thru 10/31/00
Sch. XX Question #2

a. Life Services Network	$4,523.00
b. LTCS	$1,200.00
c. Il. Nursing Home Admin. Assoc.	$75.00
	$5,798.00

Line 25, Schedule V

Repairs & Maint. (bus & van)	$533.00
Gas & Oil (bus & van)	$1,144.00
Outside Services (bus & van)	$434.00
Van misc exp.	$67.00
Insurance (bus & van)	$652.00
Employee business travel	$339.00
	$3,169.00

Line 36, Schedule V

Amortization of refinancing loan fees	$2,415.00
Bank & service fees	$121.00
Misc expenses	$1,288.00
	$3,824.00

Line 6, Schudule V

Repairs & maint. Dietary	$5,193.00
Repairs & maint. Laundry	$697.00
Repairs & maint. Bldgs	$17,761.00
Repairs & maint. Equip.	$24,503.00
Repairs & maint. Grounds	$8,047.00
Repairs & maint. Office	$4,439.00
Outside services	$6,942.00
Waste removal	$9,221.00
	$76,803.00

North Adams Home, Inc. 0020925
11/01/99 thru 10/31/00

Line 24, Schedule XVII Sec. E

Endowment funds	$26,022.00
Donated cash	$1,357.00
Memberships	$1,621.00
Mini fair income	$9,587.00
Van fund donations	$2,163.00
Donated non-cash	$380.00
Religious income	$2,484.00
	$43,614.00

Line 28a, Schedule XVII Sec. E

Discounts	$718.00
Rebates	$164.00
Admission income	$1,560.00
Activities income	$7.00
Misc. income	$534.00
Nursing supply sales	$1,295.00
	$4,278.00

North Adams Home, Inc. 0020925
11/01/99 thru 10/31/00
Sch. V, Line 23 Column #

Activity Inservice	$445.50
Documenting Discipline Inservice	$235.85
Food for Inservice	$71.85
Inservice Videos	$583.32
Handouts for Nursing Inservice on Abuse	$149.80
Financial ratios & trends	$109.00
Inservice Tapes	$48.29
Misc Inservice Supplies (handouts, etc.)	$250.36
Inservice by Christa Laphoon	$100.00
	$1,993.97

Sch. V, Reclassifications

Reclassification of Fire extinguisher recharges out of line 23 for the amount of $206.00 and reclass. $206.00 to Line 6 (maintenance outside service).